PN-ABM-169
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EVALUATION OF THE

AGENCE D'APPROVISIONNEMENT

DES PHARMACIES COMMUNAUTAIRES (AGAPCO)

HAITI

A Report Prepared By PRITECH Consultant:
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During The Period:
OCTOBER, 1989

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT
Supported By The:
U.S. Agency For International Development
CONTRACT NO: AID/DPE-5969-Z-00-7064-00
PROJECT NO: 936-5969

AUTHORIZATION:
AID/S&T/HEA: 8/7/92
ASSGN. NO: HSS 054-HA

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GLOSSARY

AGAPCO	Agence d'Approvisionnement des Pharmacies Communautaires
BID	Banque Interamèricaine de Développement
BDS	Barbados Drug Service
CARICOM	Caribbean Community
CIF	Cost, insurance, and freight
CRDTL	Caribbean Regional Drug Testing Lab
DG	Director General
ECDS	Eastern Caribbean Drug Service
HRO	Human Resource Office, USAID/Haiti
IDB	Interamerican Development Bank
MOH	Ministry of Health
MSH	Management Sciences for Health
MSPP	Ministère de la Santé Publique et la Population
OECS	Organisation of Eastern Caribbean States
OPS	Organisation Panamèricaine de la Santé
PAHO	Pan American Health Organization
RHDS	Rural Health Delivery System

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DOCUMENTS CONSULTED

Both as an activity within the RHDS Project and as an example of an attempt to establish a public sector drug sales program in a developing country, AGAPCO's evolution has been well-documented. Planning documents, training and reference manuals, progress reports, and consultant's trip reports exist in abundance. As part of its planning process for a major health project in the public sector, the World Bank has funded two consultants' assessments of the AGAPCO system during the past eighteen months. During the final stages of the RHDS Project, both an evaluation of financial planning and management at AGAPCO and a marketing study were conducted for AGAPCO. These four documents are cited here, along with a recent paper comparing AGAPCO with an AID-funded project in the Eastern Caribbean. Other relevant documents are cited as references within these reports. The fifth document cited here is the report submitted to the MSPP shortly after the new Director General of AGAPCO took office four months ago; this report describes AGAPCO's weaknesses and management's strategy to correct those weaknesses. Finally, numerous documents internal to AGAPCO, including annual reports for the previous four years, were consulted during the evaluation process. Documents were available and easily retrieved within AGAPCO's central offices.

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EXECUTIVE SUMMARY

In 1981, the *Agence d'Approvisionnement des Pharmacies Communautaires* (AGAPCO) was established under the USAID-funded Rural Health Delivery Systems (RHDS) project, a thirty-three million dollar ($33,000,000) bilateral agreement with the government of Haiti through the *Ministère de la Santé Publique et la Population* (MSPP). AGAPCO was established as a semi-autonomous agency of the MSPP. Its mandate was to provide a limited list of essential drugs at an affordable price to the most disadvantaged segments of Haiti's population. It was also expected to become financially self-sufficient within a five-year time span.

As a project within a project, AGAPCO was referred to fondly as the "royal crown jewel of the RHDS project." It was also a highly complex and overly-ambitious undertaking. Rapid expansion was attempted before the fledgling organization had learned to be either effective or efficient within its initial sphere. Errors were made in the planning stages, particularly in relation to the procurement of pharmaceuticals. In 1985 the specter of *auto-suffisance* was retreating, and, as is often the case, public health goals were in conflict with financial goals. Nevertheless, AGAPCO continued to carry out a remarkable range of activities, and management continued to work steadily to solve the existing problems, including procurement, inventory management, marketing, and financial management.

The Technical Assistance (TA) contract was completed by mid-1986. (Prior to that time AGAPCO had been receiving approximately two person years of TA each year for five years.) In November of 1987 all USAID funding to the public sector, including AGAPCO, was terminated.

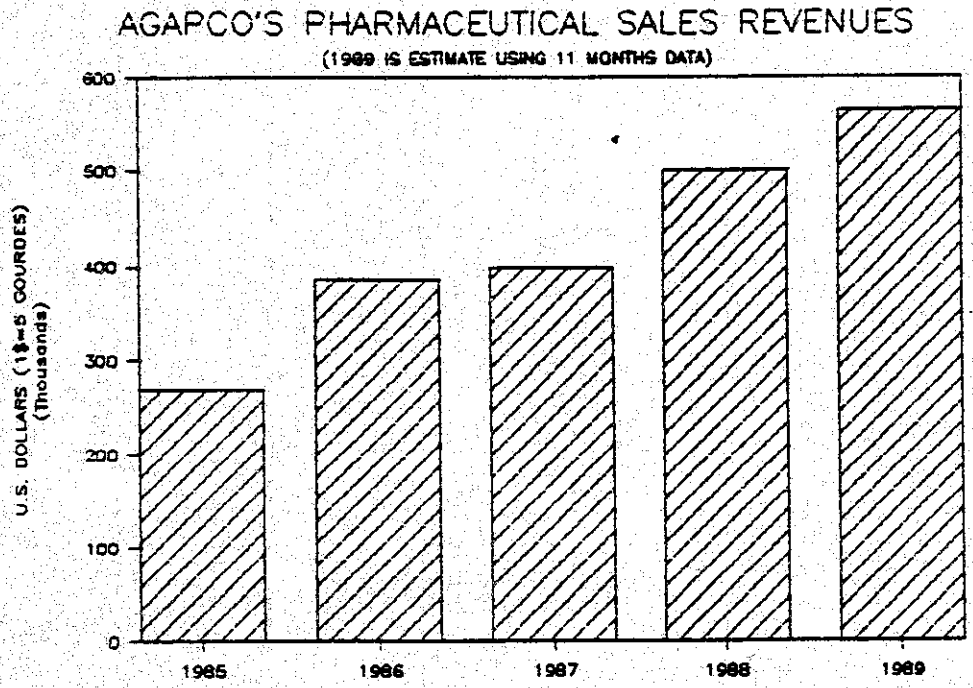
In mid-1989, with a view to renewing aid to AGAPCO, the USAID/Haiti mission requested PRITECH assistance in an evaluation of AGAPCO's past performance and present management capacity.

This evaluation report will focus on AGAPCO's experience during the past four years. In evaluating that experience and current organizational capability, we must consider the withdrawal of both the financial support and the scrutiny of USAID, and the political and economic instability that has undermined organizations that seemed more firmly rooted than AGAPCO did in late 1985. When we consider experience with and realistic expectations within the current Haitian context, it is remarkable that AGAPCO has even survived.

Evaluations of AGAPCO's performance in late 1985 indicated a number of negative trends in critical indicators. Trends from 1985 through 1988 (and available data for 1989) have shifted from negative to positive, although the ascent is sometimes subtle.

Revenues from drug sales have risen. (See Figure 1.) Since they have increased more than the price increases, this indicates an

FIGURE 1



increase in the distribution of essential drugs. Operating costs have declined slightly. Real operating deficits have declined (i.e. deficits that result from operations and are not influenced by the flow of donor funds). Losses related to the expiration of drug stocks have been reduced significantly.

Staff turnover has been low when compared with what has been typical in the public sector; average tenure is four years. Key staff members have good qualifications. Although the Director General's (DG) position turned over during 1989, there has been unusually good communication between the current and past DGs, and, therefore, continuity for AGAPCO. Continuity in AGAPCO's staffing and the learning curve that AGAPCO has experienced have contributed to the quality of management decisions that have supported the improvements in critical indicators.

AGAPCO is a complex organization involved in the purchasing, repackaging, distribution, and sale of pharmaceuticals. The control and information systems related to the flows of funds and drugs through a network of AGAPCO warehouses and pharmacies are equally complex. Yet all of these systems, both manual and computerized, appear to have continued to function well. Printed forms are still provided to and maintained at the peripheral levels of the system, as well as at other levels. Information on inventories in the warehouses, revenue flows from each outlet, and costs are readily available in the central offices, either through the general ledger system or computer data bases. Other administrative systems are also functioning well.

AGAPCO appears to have improved its relationship with the MSPP both at the central level in Port-au-Prince and at the peripheral level through more frequent meetings with the doctors and nurses who manage and staff the facilities were AGAPCO pharmacies are located. Nevertheless, AGAPCO needs to continue to develop its relationship with the MSPP and gain further integration and support within the health care system: over eighty percent (80%) of AGAPCO's pharmacies are located in MSPP facilities.

The notable exception to these signs of progress is the expected decapitalization that has taken place. Full financial self-sufficiency (including the cost of drugs and system operating costs) was not a realistic goal within the Haitian context, particularly not within a five year period. With growing cash flow shortages, AGAPCO has resorted to purchasing drugs locally in smaller and smaller quantities which has further increased the base purchase price. Such hand-to-mouth operations support neither the mandate to provide essential drugs at a low price nor the organization's cost-recovery goals.

In addition to decapitalization and poor procurement practices, AGAPCO is plagued by a number of other problems that are discussed in this report, but AGAPCO has made progress in a difficult environment. Given both the current institutional capacity and its proven tenacity, further support to AGAPCO is well warranted. If USAID is committed to supporting the provision of low cost, essential medicines to the most disadvantaged segments of Haiti's population, then the renewal of support to the AGAPCO system is clearly the best strategic alternative. As one USAID professional said, "This is something that we shouldn't let perish."

Although other recommendations for AGAPCO's management are integrated into the report, the four strategic options suggested below should be considered a short-term priority plan to give AGAPCO immediate support. These recommendations are directed to USAID personnel who have responsibilities in the health care sector because of AGAPCO's critical need for immediate external support.

However, other recommendations for AGAPCO that are incorporated into the body of the report are equally important because there are a number of useful things that can be done immediately. AGAPCO could benefit from external assistance in implementing most of these recommendations (which are necessarily brief given the nature of this report); however, for most activities, it would be premature to develop plans for technical assistance inputs until the recommendations contained in the executive summary have been acted upon.

KEY RECOMMENDATIONS for USAID:

1. Identify sources of funding (local or US$) that can be used to support AGAPCO. The most pressing need is funding for the pur-

chase of drugs, and this should be given the highest priority. It would be best if at least five hundred thousand dollars ($500,000) could be provided to support the purchase of drugs in bulk, thus lowering the unit costs; however, any support will help. (A more exact calculation of AGAPCO's financial requirements for drug procurement was beyond the scope of this "evaluation.") Unless more than $500,000 can be provided, purchasing will probably have to continue locally because the lead times for international suppliers will be too long. Other expenses that require support are supervision and promotion (through transport and perdiem costs) and operating systems (through printing of forms and refresher courses for regisseurs).

2. Identify other USAID projects that can be used to support AGAPCO. This support could include the direct purchase of drugs from AGAPCO through other projects as well as more indirect support, such as ORS posters that mention the availability of good quality, low-cost ORS as AGAPCO. USAID can also encourage meetings between AGAPCO management and health care professionals in other USAID projects/organizations; this would further strengthen AGAPCO's professional networks. Several of the current private sector projects offer possibilities, as do centrally-funded projects based in the U.S..

3. Organize a visit to the Eastern Caribbean Drug Serviced (ECDS) in St. Lucia for a delegation from Haiti composed of the Minister of Health, the Director General of AGAPCO, and one USAID staff member. (The USAID staff member should be fluent in English, French, and Creole.) The ECDS was established under a USAID grant, and can provide the delegation with practical ideas in three areas of mutual interest. First, the Policy Board and two technical sub-committes that form part of the ECDS's organizational structure should give AGAPCO and the MSPP some excellent ideas about how they could reshape and develop the role of the *Conseil d'Administration* and possibly other professional committees that could support and develop the AGAPCO network. This particular aspect of organizational structure and development is a strength for the ECDS and a weakness for AGAPCO, so there is much potential for AGAPCO and the MSPP in an exchange of ideas. Second, the ECDS tendering/procurement systems provide a good example of international pharmaceutical tendering. This experience will not benefit AGAPCO or the MSPP in the short-term, because they would require large amounts of cash in foreign exchange in order to replicate the ECDS systems. However, in the long-term, the example should provide useful ideas that may be implemented at AGAPCO. Finally, the ECDS has a public sector monopoly through a sole source commitment with the seven Ministries of Health. Since, the Minister of Health in Haiti has expressed his willingness to make AGAPCO the sole procurement agency for the MSPP, it would be useful to see how this arrangement has worked for the ECDS in the Eastern Caribbean.

This evaluation team will be responsible for making initial contact with the OECS and the ECDS to discuss the possibility of a visit from a Haitian delegation in early 1990. USAID/Haiti will

be kept informed about these discussions.

4. Work with AGAPCO management, MSPP officials, key health professionals, and representatives from other donor agencies to redefine AGAPCO's goals and objectives and develop a strategic plan. This should include establishing more modest financial goals such as covering the costs of pharmaceuticals only, which would require that administrative costs be covered by the MSPP or another source. (The Minister of Health has expressed his willingness to delegate or transfer members of the MOH staff to AGAPCO personnel there need to be replaced in the future.)

Plans should also include a strategy for further participation from key Haitian health care professionals in the selection of AGAPCO's product line.

Long-term plans should include a focus on improving the method of procuring pharmaceuticals (including quality assurance through procurement); supervising and supporting the distribution network; rationalizing the pricing policies; and other aspects of AGAPCO's operations that are discussed in the body of this report. A marketing plan should be developed, including a strategy for communicating information about AGAPCO products to health care professionals which begins with the revision, publication, and distribution of a new AGAPCO vademecum. Discussions and plans should focus on developing AGAPCO's relationship with the entire health care delivery system, from the grassroots to the policy level, and improving its ability to serve that system.

I. AGAPCO'S EVOLUTION, ORGANIZATIONAL GOALS, & INSTITUTIONAL RELATIONSHIPS

In 1981, the *Agence d'Approvisionnement des Pharmacies Communautaires* (AGAPCO) was established under the USAID-funded Rural Health Delivery Systems (RHDS) project, a thirty-three million dollar ($33,000,000) bilateral agreement with the government of Haiti through the *Ministère de la Santé Publique et la Population* (MSPP).

AGAPCO was established as a semi-autonomous agency of the MSPP. This "semi-autonomous" status has been the source of much debate, concern, and confusion both in the past and currently. This debate encompasses the legal interpretations, the shifting realities of the behavior of both the MSPP and AGAPCO over time, and various concerned parties' perceptions of what AGAPCO's independence from the MSPP is or should be. This complex issue should be a priority for the discussions suggested under recommendations 3 and 4 in the executive summary, as it impacts all aspects of AGAPCO's operations. Satisfactory resolution of the issue will depend on the policies and organizational relationships of a variety of actors, both donors and Haitian governmental institutions, as well as the representatives of those organizations. This report should help to focus a discussion on the current realities at AGAPCO, rather than what might have been done in the past. However, since the problem itself is political rather than technical, it cannot be resolved by a recommendation here.

AGAPCO's mandate was to provide a limited list of essential drugs at an affordable price to the most disadvantaged segments of Haiti's population. It was also expected to become financially self-sufficient within a five-year time span.

Both as an activity within the RHDS Project and as an example of an attempt to establish a public sector drug sales program in a developing country, AGAPCO's evolution has been well-documented. Planning documents, training and reference manuals, progress reports and consultant's trip reports exist in abundance. Four case studies have been developed, and the two that deal with financing and financial management have been taught in four institutions during the past year. Many health care professionals working in developing countries have benefited from AGAPCO's experience.

In many ways they have learned from the mistakes. In late 1985, AGAPCO had experienced flat revenues over the previous two years, while operating costs were rising rapidly. Many of the products that had initially been selected were simply not selling, and the value of drugs lost through expiration in 1985 was in excess of the value of drugs sold through the system during the fiscal year. Nevertheless AGAPCO had accomplished much. Staff were trained. Systems to manage inventory, distribution, and financial transactions were designed and implemented. A network of approximately two hundred (200) pharmacies had been established.

For a variety of reasons, including the lack of clarity in the "semi-autonomous" status, relationships with the MSPP were ill-defined and sometimes strained. After the first year, the MSPP bought little directly from AGAPCO, although, as the system evolved, the majority of AGAPCO pharmacies were established in MSPP facilities that purchased directly from AGAPCO.

The amount of support that AGAPCO has received from the MSPP has shifted over time. In the past AGAPCO may have been perceived more as an agency of USAID than of the MSPP; the behavior of AGAPCO's management and advisors from the TA team may have supported this perception. Although the initial design plan anticipated that the MSPP would buy a large portion of AGAPCO's drug stocks, such purchases never materialized beyond the first year or two of operations. Since autonomy from the MSPP generally meant that AGAPCO could implement plans more rapidly, activities tended to take place with a minimum of coordination between AGAPCO and the MSPP. At the same time, the majority of AGAPCO's pharmacies were situated in MSPP facilities, which meant that the absence of coordination risked undermining the pharmacy network. Figure 2 illustrates the institutional relationships that existed prior to the termination of USAID funding. It is important to recognize that there is close physical proximity between AGAPCO, USAID, the MSPP, and the pharmaceutical suppliers, while the majority of the pharmacy network is outside of Port-au-Prince.

The institutional relationship between AGAPCO and the MSPP appears to have strengthened. This is the result of efforts from both sides.

At the roots of the system, AGAPCO personnel have begun to work more closely with the doctors, nurses and other health providers at the district level and regional level. Naturally, these activities are suffering as a result of the shortage of travel funds. Continuation of these activities is essential, especially when one considers that there is no formal legal relationship between AGAPCO and the pharmacy network. Pharmacies are managed and operate independently from AGAPCO. The personnel who manage them are usually MSPP staff rather than AGAPCO staff; the health providers who drive the demand for pharmaceuticals are usually MSPP staff.

At the central level, relationships have also improved through more frequent communication and a recognition of mutual goals. The Minister of Health has expressed support for AGAPCO in several critical areas. Without changing the legal relationship, he would like to bring the two organizations closer together in several tangible ways. First he plans to make AGAPCO the sole procurement agency for the MSPP for any of the product lines that are available through AGAPCO. This would in effect give AGAPCO a monopoly in the public sector and create a powerful form of support. (The ECDS in St. Lucia also has a public sector monopoly, through a sole source agreement with the seven MOHs in the sub-region.) Second, the Minister intends to absorb the AGAPCO

staff into the MSPP payroll. He would like to redefine AGAPCO's cost recovery objective to include recovery of only the direct costs of pharmaceuticals. If these two policies are implemented, AGAPCO's future prospects could be radically improved.

The physical relocation of AGAPCO's offices has also improved its relationship with the MSPP. The offices, located at Post Office Square in the same building as the MSPP Region Ouest, are more attractive and more accessible to both AGAPCO clients and MSPP personnel.

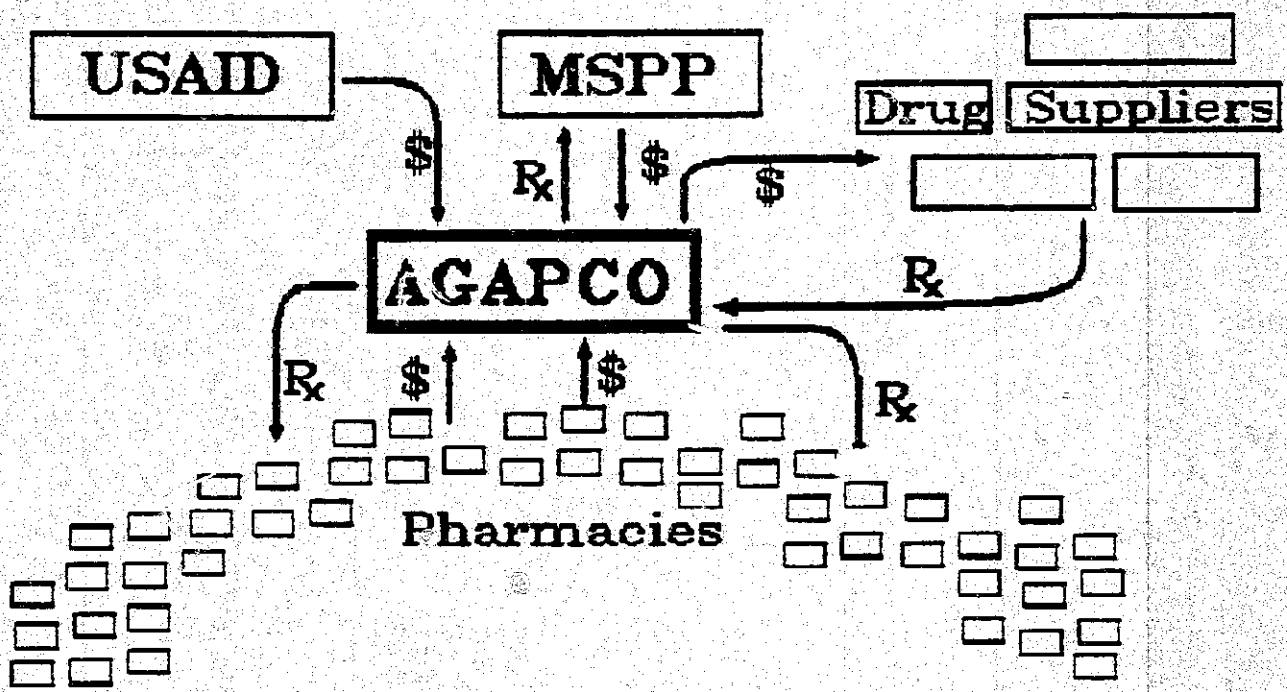
AGAPCO should also attempt to develop its relationship with the Private Voluntary Organizations (PVO) and Non Governmental Organizations (NGO). This could be accomplished through more frequent meetings with PVO/NGO personnel, through the creation of an PVO/NGO Advisory Committee, or through inclusion of key representatives on the *Conseil d'Administration.*

AGAPCO should continue to develop its relationships with the donor community, both through direct contact with individual representatives, and through membership on the *Conseil d'Administration* or a special committee that could be developed under that body.

The *Conseil d'Administration* has never really functioned, although, like AGAPCO's semi-autonomous status, it has from time to time been the topic of much discussion. Recommendations 3 and 4 in the executive summary are intended to develop ideas about how this body (or this body combined with supporting committees) might be developed and made functional. The ECDS in the Eastern Caribbean operates under the direction of a Policy Board with two subcommittees specializing respectively in the formulary and and procurement functions of ECDS. Supporting and organizing these advisory bodies takes a significant amount of energy from the ECDS staff, and it may be that in Haiti the effort required to organize and make functional external bodies has been underestimated in the past. The importance of having this external source of both support and guidance may also have been underestimated.

FIGURE 2

INSTITUTIONAL RELATIONSHIPS
PRIOR TO THE TERMINATION OF USAID FUNDING



II. ORGANIZATIONAL STRUCTURE & HUMAN RESOURCES

Figure 3 is an organization chart for AGAPCO, as revised during the past six months under the new Director General. Planned adjustment from the previous structure have been implemented, so this should represent the current structure.

Currently, AGAPCO has a staff of thirty-five. (See Table 1.) The average tenure of a staff member is four years; this is generally much better than some departments of the MSPP, where rapid staff turnover can mean that systems collapse or are never properly entrenched. The Director General (DG) position has turned over five times since AGAPCO was established; however the selection of the current DG, appointed in May, 1989, was influenced by the previous DG who had stayed in the post for five years. This again is in significant contrast to what has happened to key positions at the MSPP during the past five years.

Although a number of the key positions at AGAPCO have turned-over during the past year, there has been a good continuing relationship between the past and current DGs, and newly-appointed personnel appear to have excellent qualifications. The DG is an M.D., M.P.H.; the Technical Director is a Pharmacist with a variety of previous experience; the Administrator is a Haitian who has just returned after seventeen years in Montreal where he was involved in hospital administration. The recruitment process appears to be good, and personnel folders including resumes and job descriptions were available for all staff members. A variety of other personnel administration systems are in place, although day-to-day operations may be somewhat uneven in cases (e.g. timesheets), they appear to be operating as well as would be expected in a well-managed organization.

AGAPCO's staff appears to be competent and committed to the organization; however, if additional financial support for salaries is not made available soon, AGAPCO management should consider cutting back on the central staff through attrition (i.e. not replacing staff members who leave). Some of the key staff members are clearly very busy while others are not. This problem is probably a result of the lack of funds: e.g. those responsible for supervision and promotion cannot travel without funds for per diem and gas. If funds were available for travel, AGAPCO might not be over-staffed.

Since one of the reviewers of this report in the original draft commented on salary levels, it would be useful for USAID to compare individual salary levels with those of similar positions in AID-funded projects, particularly if future support for operating costs at AGAPCO is considered. However, significant salary increases made during the years compared in the financial data later in this report were approved and funded by AID during the grant period.

FIGURE - 3

AGAPCO ORGANIZATIONAL CHART

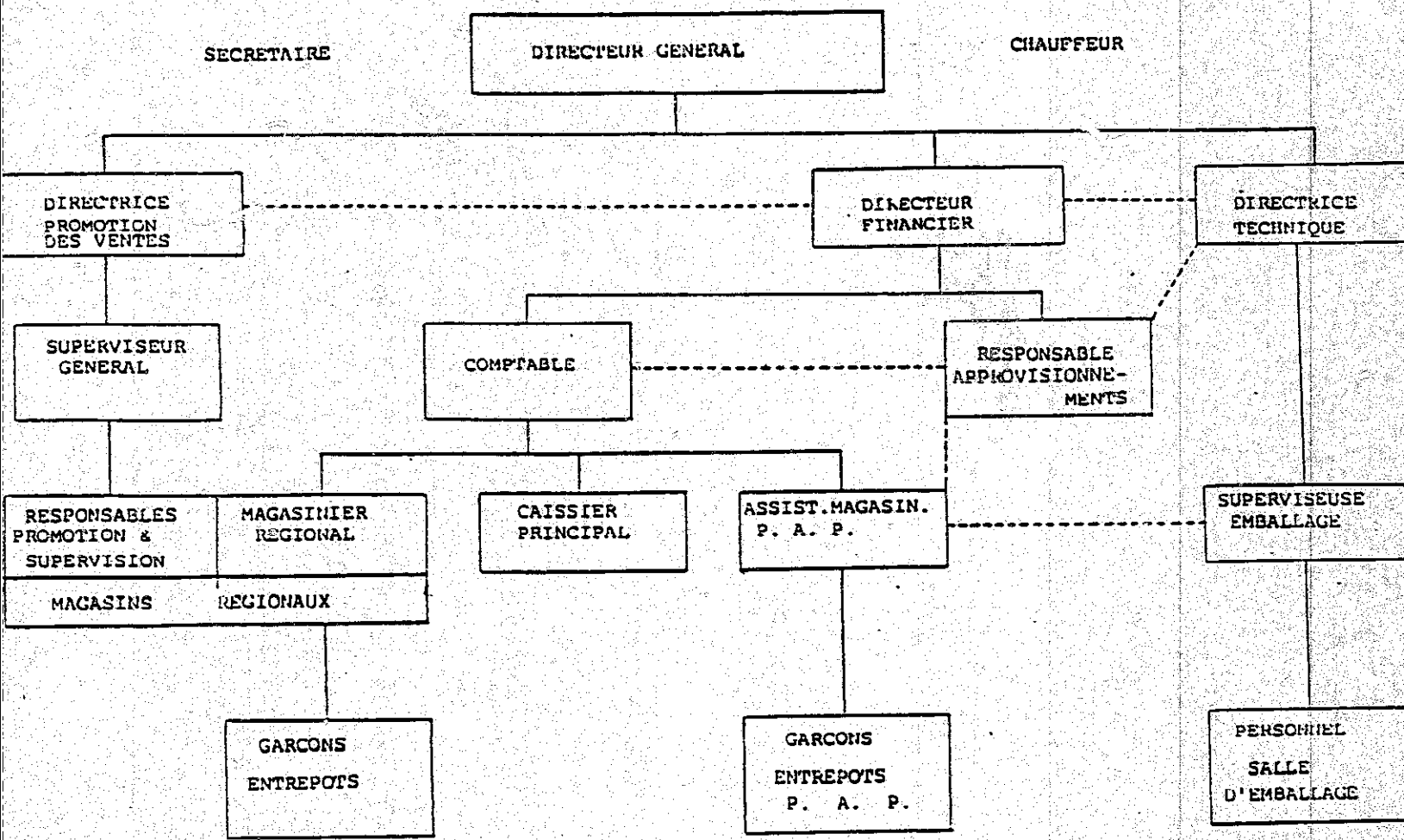


TABLE 1 - AGAPCO PERSONNEL
(SEPTEMBER, 1989)

NOM, PRENOM	FONCTION	POST	DATE EMPLOYED	MONTHS EMPLOYED
SAMSON, MARIO	DIRECTOR GENERAL	P-AU-P	May-89	4.69
CEDRAS, YANICK	CHEF SERVICE TECHNIQUE*	P-AU-P	Feb-89	7.26
PIERRE, JEAN CLAUDE	ADMINISTRATEUR	P-AU-P	Feb-89	7.26
RACINE, GINETTE	APPROVISIONNEMENT	P-AU-P	Oct-81	94.88
JEAN, DOMINIQUE	CHEF SERVICE FINANCIER	P-AU-P	Dec-86	32.77
CHARLES, MARIE ALICE**	SUPERVISEUR GENERAL***	P-AU-P	Feb-89	31.26
ST.DIC, PAULETTE	RESPONSABLE PROMOTION*	P-AU-P	Feb-89	7.26
MAGLOIRE, RENALD	COMPTABLE	P-AU-P	Jan-86	44.64
FRANCOEUR, CLAUDINE	SECRETAIRE	P-AU-P	Nov-86	34.18
LONGIN, JOSUE	SUPERVISEUR	P-AU-P	Nov-86	34.18
LEBLANC, MIGUEL	RESPON. DEPOT CENTRAL	P-AU-P	Nov-86	34.71
CHARLES, JOSEPH	MAGASINIER	TRANS.	Dec-85	45.63
AMBROISE, MARCEL	MAGASINIER	NORD	Jun-82	87.31
LYCE, MIREILLE	MAGASINIER CENTRAL	P-AU-P	Apr-88	17.52
GUILLAUME, FRANCILLON	CHAUFFEUR	P-AU-P	Apr-83	76.99
SICLAIT, CHARDIN	CAISSIER	P-AU-P	May-86	39.94
MAGNAN, ANDRE-FRANCOIS	ASSIST. MAGASINIER	P-AU-P	Mar-87	30.14
GUERRIRO, ANTOINE	ASSIST. MAGASINIER	TRANS.	Apr-86	40.86
BLAISE, FRANTZ	MAGASINIER	SUD	Jul-83	73.80
NORESIAS, JACQUES	ASSIST. MAGASINIER	NORD	Sep-86	36.26
BLAISE, THERESE	ASSIST. MAGASINIER	SUD	Jan-86	44.64
LOUIS, MAUDE	SUPER. EMBALLAGE	P-AU-P	Apr-82	89.12
FEDHERSE, JOSEPH	ASS. RES. DEPOT CENTRAL	P-AU-P	Oct-87	23.60
BEMADEL, NAHOMI	ASSIST. MAGASINIER	P-AU-P	Feb-89	7.26
PIERRE, ACELIA	EMBALLEUSE	P-AU-P	Jun-82	86.89
JEUNE, BESOIT	OUVRAGE GENERAL	P-AU-P	Jun-83	75.31
CADET, DIENOLLA	EMBALLEUSE	P-AU-P	May-82	88.73
LEYS, CONTAVE	OUVRAGE GENERAL	P-AU-P	Jun-83	75.31
FAUSTIN, MELANIE	EMBALLEUSE	P-AU-P	May-82	88.73
DOLCE, SOEURETTE	EMBALLEUSE	P-AU-P	Apr-82	89.15
NOEL, YOLAND	EMBALLEUSE	P-AU-P	Apr-82	89.15
MARVAL, JOSEPH	OUVRAGE GENERAL	CAYES	Dec-84	57.63
ST.LOUIS, SAINVILUS	OUVRAGE GENERAL	GONAIVES	Dec-85	45.69
DUCATEL, THEOGENE	OUVRAGE GENERAL	NORD	Oct-88	11.57
GLAUDE, GERARD	PHARMACIEN*	P-AU-P	Aug-89	1.70
		AVERAGE TENURE:		47.31

* PHARMACISTS
** SPENT TWO YEARS PREVIOUSLY WITH AGAPCO
*** ALSO RESPONSABLE FOR MARKETING

Although all systems appear to be operating well, there are less staff members with good computer skills at this time. The *Chef Service Financier* should train the *Comptable* in the use of Lotus 123 files associated with the financial systems, and the *Administrateur* should develop his knowledge of AGAPCO's computerized systems. The former DG and Chief Accountant did much of the computer work, but the Administrater should be able to manage the computer systems so that the new DG can concentrate on developing external relationships, particularly with the medical community.

Other staff members, particularly those involved in supervision and promotion, should also develop their computer skills, particularly during this slack period when funds are not available for travel and transport. Performance profiles for individual pharmacies should be developed and maintained in computer files. It would also be very useful for AGAPCO to produce graphics, using Lotus 123, of currently available data and other data that could be collected. This type of pictorial information would be very useful for AGAPCO to keep interested individuals informed and to promote itself.

Other useful activities that could be conducted, particularly while the central office staff has available time, are discussed under Section VI, "Supervision, Communication, and Promotion."

In the long-term, if it is possible to find external funding, it would by useful for the Director General, the Technical Director, and the Administrater to attend the "Managing Drug Supply" courses offered by Management Sciences for Health (MSH). These courses are offered in French as well as in English, usually in Boston. If external funding cannot be made available, copies of the training materials should be available through MSH.

As mentioned in the executive summary, the suggestions given here are necessarily brief. In order to develop them more fully and implement them, AGAPCO would benefit from technical assistance but this would only be appropriate once the larger steps discussed in the executive summary have been completed.

III. PRODUCT SELECTION, QUALITY ASSURANCE, & PROCUREMENT

When AGAPCO was first established, there was no good data available on drug utilization through the public sector system. Disease prevalence rates and population data were combined to develop a list of essential drugs in estimated annual quantities. The product list and quantities were thus based on epidemiological need - not demand. Demand through private pharmacies or through a sampling of prescribing patterns was not assessed. Generic name drugs were also selected, although much prescribing was done on the basis of brand names. As anyone involved in family planning activities knows, you cannot plan inventories for sale on the basis of perceived "need" while ignoring the real demand.

In terms of product selection, the Minister of Health, the Director General of AGAPCO, and Dr. Josette Bijou (currently with the World Bank and previously the MSPP Director of the Region Sud), along with other key professionals, are concerned about educating health providers in Haiti so that prescribing habits will gradually tend more toward essential, generic name drugs that are effective and affordable for the MSPP system. This process of behavior modification is critical, but it will also take years to achieve success in any conspicuous form In the meantime, AGAPCO needs to conform to the rational aspects of demand that currently exists; since they AGAPCO system had now been operating through most of the 1980's, it can provide its own demand data. (For further discussion on modifying demand patterns, see Section VI.)

At the same time, AGAPCO needs to encourage rational demand through the selection of its products. As is often the case, financial goals may be in conflict with public health goals, and there could be a tendency to move toward a more commercially viable selection of products. Such movement may be appropriate or necessary to a degree, but AGAPCO needs to maintain a balance between the financial and social goals. The World Bank report by Bisaillon provides a detailed analysis of the products that AGAPCO has been carrying as well as commentary on the published (now out of date) vademecum from a pharmacological perspective.

Given the combination of project urgency and the need to adhere to USAID regulations that were difficult to understand, the first orders did not go through a tendering process that could result in the most competitive base prices. AGAPCO's pricing policies (see Section V) at the time, when combined with high base prices, meant that AGAPCO's wholesale prices were often not competitive.

At the end of fiscal year 1985, its second year of full operation, AGAPCO wrote off over three hundred and sixty thousand US dollars ($360,000) worth of stock.

Later, as AGAPCO generated its own revenues to repurchase drug supplies, it was constrained to buying from local suppliers and

UNICEF because of the shortage of foreign exchange. Although *appel d'offres* (local tender offers) were published in the newspapers, the procurement process was much less competitive than it would have been if foreign suppliers or international agencies had been sources of supply.

Currently, because of the shortage of working capital, AGAPCO is confined to local procurement, in relatively small quantities. The *appel d'offres* system is no longer used, and the system of requesting three pro-forma invoices is now used infrequently. AGAPCO is buying primarily through five local suppliers: Pharmacie Vallieres, Pharval, Laboratoire 4-C, Medical Supplies, and Reinbold. The Procurement Specialist estimates that approximately seventy percent (70%) of the purchases go through the first three suppliers listed above. Each procurement is made through negotiations with individual suppliers. Given the situation, this is quite normal, but it certainly does not help AGAPCO to reduce the basic purchase price. However, without funding to increase available working capital and access to foreign exchange, there is no other procurement method that AGAPCO can employ.

The Procurement Specialist has been with AGAPCO from its beginnings and has worked her way up through the ranks from a post as Secretary. Her long-term experience with AGAPCO provides the advantage of good institutional memory; she would definitely benefit from exposure to other procurement systems (such as the ECDS in St. Lucia), and this should immediately be made a top priority if and when AGAPCO has the potential to change its method of procurement through the provision of significant addition working capital.

AGAPCO's Director General is concerned about the lack of any drug testing facilities to provide quality assurance for AGAPCO products. One possiblity that has been considered is the creation of a drug testing lab in Haiti. Another suggested option was an agency based in the Dominican Republic. Another possibility that was discussed was the Caribbean Regional Drug Testing Lab (CRDTL) in Jamaica.

Non of these possibilities is recommended for AGAPCO during the next several years. There are complications and risks associated with each of tne three alternatives, but, more importantly, AGAPCO could gain much more quality assurance through its procurement process. The selection and monitoring of suppliers and enforcement of supplier contracts can provide much more quality assurance (particularly for the resources invested) than lab testing. Since most testing would also be done "after the fact" when drugs have already arrived at AGAPCO, quality assurance through the procurement process follows the medical adage of "an ounce of prevention being worth a pound of cure."

In the future when maximum protection has been assured through the procurement process, lab testing facilities can be considered. At that time AGAPCO would find it useful to tap the expe-

rience of other agencies and countries in the Caribbean involved in lab testing of their products, particularly the CRDTL and the agencies and ministries using its services. The costs, benefits, and demand experienced for these services should be of particular interest.

Procurement is a crital weakness in the current AGAPCO system. Again, suggestions made here are necessarily brief. This is another area where AGAPCO could benefit both from technical assistance and exposure to the ECDS system, but this would only be appropriate after the recommendations in the executive summary have been successfully implemented.

IV. INVENTORY MANAGEMENT & DISTRIBUTION SYSTEMS

When AGAPCO was first being established, it was estimated that approximately fifteen (15%) of the drug imports went through the MSPP system, with nearly one-third of these, or five percent (5%), going to the University Hospital. The MSPP system included 178 clinical facilities, but drugs usually went to district hospitals and larger health facilities. The MSPP had no system wide stock control or other supply management procedures. Recipients collected their stocks, and there was apparently no systematic method for sharing an allotment procured at the central level

Since it was first established AGAPCO has opened approximately two hundred (200) "AGAPCO" pharmacies. Approximately half of these were opened during 1985 in a rush to increase revenues through an expansion of the pharmacy network. Toward the end of 1985, realizing that the strategy had not been effective and had distracted attention from important issues, AGAPCO stopped creating pharmacies: very few were opened in 1986 or later. The number of pharmacies that can still be considered reasonably functional is probably between one hundred and twenty and one hundred and forty (120-140); however, most of the pharmacies failed within a year or eighteen months or being opened, rather than during the most recent four years, primarily as a result of poor site selection and initial support.

The original concept was that AGAPCO would establish "community" pharmacies that were managed by the community councils. However as the network evolved, most of the pharmacies were established as institutional pharmacies managed by staff within the institution. Over eighty percent (80%) of the pharmacies that AGAPCO still considers somewhat functional are institutional, only a dozen are in Port-au-Prince. Since these pharmacies are managed by MSPP personnel, the need for greater collaboration between the MSPP and AGAPCO is clear.

Information an the current state all pharmacies is weak: AGAPCO needs to make a concerted effort to assess the state of the network and strengthen it.

During this short visit we were only able to visit six (6) pharmacies: Petit Goave and Miragoane in the rural districts, and four others in the metropolitan district. The two pharmacies in the rural districts are described in more detail below, because they should be more typical than those in the metropolitan area. However, although they were several hours drive from Port-au-Prince, they were not in remote areas.

The pharmacy at Petit Goave had been operating for six (6) years. The pharmacy was marked with an AGAPCO sign. Records were reasonably well organized. All products were from AGAPCO and none appeared to have expired. Ten (10) of the forty-eight (48) items that they normally carried were out of stock; all but one of these were apparently available at AGAPCO's central warehouse.

The appearance of the pharmacy was reasonable, but it could have been cleaner and neater. The young woman who was functioning as the regisseur had been there for four months and had not seen anyone from AGAPCO during that period.

The hospital pharmacy at Miragoane had been operating for five years. The pharmacy was marked with two different AGAPCO signs, however only twenty-five or thirty percent (25-30%) of the products on the shelves were from AGAPCO. AGAPCO forms and records were no longer in use, and we did not attempt to calculate stock-outs. Products that had been purchased outside the AGAPCO system included items such as appetite enhancers, anti-flatulents, and cough syrups. The pharmacy was very clean and organization was good. Two people from AGAPCO had visited approximately a year earlier. (This may also have been a World Consultant team.)

The four pharmacies in Port-au-Prince were all in MSPP facilities, and had all been established six years ago (1989). The pharmacies were carrying AGAPCO products exclusively, except for a few items in one pharmacy. With the exception of one pharmacy, they had minimal or no stock-outs. The pharmacy that suffered from major stock-outs had no cash to buy stock, and the AGAPCO supervisor encouraged her to buy on credit. The general appearance and utilization rates in the four pharmacies ranged from adequate to good in conformance with the health facilities were they were located. The AGAPCO record keeping systems appeared to be operating well, although in two cases we were unable to see all of the records because they were retained by an Administrater who was not available. All pharmacy staff clearly had good relationships with the AGAPCO staff and received visits at least once or twice a month.

Inventory management in individual pharmacies depends on the individual regisseurs or other health facility managers. The pharmacies have to request new inventories, and usually travel to AGAPCO to get them. This "pull system" is a major contributing factor in stock-outs at the pharmacy level, although shortage of funds and other issues clearly contribute. However, if AGAPCO minimizes stock-outs at the central level and in the regional/district depots, this is a major improvement over the MSPP system that pre-exited AGAPCO.

According to AGAPCO management, there were only a few stock-outs at the AGAPCO level and these were due to supplier stock-outs; however there were many products with very minimal stock levels. The inventory management systems at AGAPCO are still operating at all levels. A physical inventory is taken in all warehouses every quarter, and one was underway (to correspond with the end of the fiscal year) during this evaluation period. Comparisons between cardex inventory records and the count for the last physical inventory were also available. Information on fiscal year-end stock (i.e. September 30) should be available by mid-October.

In the past, AGAPCO was not doing a very effective job of combining data on current stock levels, historic demand, and expected supplier lead times in order to make procurement decisions. This is still the case, but, because of the current hand-to-mouth operations where drugs are only purchased locally when a product is almost out of stock, it is not possible to do otherwise. The current procurement system, aside from its other faults, does not encourage rigorous stock management practices through the use of inventory data for planning at AGAPCO. Nevertheless, although we were unable to conduct a detailed audit of the inventory management systems, they appear to have continued to function at a reasonable level. The information in the record keeping systems is still used well for control purposes, but, unfortunately, is not and cannot currently be used for planning purposes. The systems are a major improvement over what pre-existed AGAPCO and much better than what is typically found in developing countries. There does not appear to have been any deterioration in them during recent years.

The current fleet of six AGAPCO vehicles, three in Port-au-Prince and three in the regions, is aging. There are plans for the acquisition of two additional vehicles in an upcoming World Bank project. Because of the state of deterioration of the existing vehicles, AGAPCO's Director General thinks that, in addition to the two vehicles provided by the World Bank, AGAPCO needs two more vehicles.

As with other areas, AGAPCO could benefit from technical assistance in strengthening its inventory management and its distribution systems and the recommendations given here are necessarily brief. However, there is much AGAPCO can do with its own existing staff and without external assistance, and the assessment of the true state of the pharmacy network should be a high priority for staff activities at AGAPCO.

V. FINANCIAL MANAGEMENT & PLANNING

AGAPCO's financial systems, which are partially computerized in the central office, appear to be functioning well. These systems, particularly at the central level, provide good control (through audit trails) and good managerial information.

Sales are controlled through requisition/voucher numbers and receipt numbers. The majority of sales are for cash. For consignment or credit sales, balances are maintained for individual facilities. With the exception of three facilities, the repayment of credit sales has been reasonably good recently. For all cash sales, the central office maintains a current monthly record of sales and thus trends in revenues. Expenses paid out of cash revenues received in the regional/district depots are recorded appropriately by the depots, but it is not clear whether the Central Office records them as expenses or simply a reduction in revenues received. However, these expenses are minor. Cash collected is maintained in two bank accounts that are used to fund expenses, including the purchase of drugs.

The central office produces a monthly general ledger with expenses listed by voucher, cheque number, payee, and expense category. This system is computerized and appears to be operating both promptly and accurately. With the exception of petty cash and the regional/district expenses noted above, expenses, including the payroll, flow through the bank accounts.

This is a double-entry accounting system that produces standard financial statements at the end of each fiscal year (i.e. September 30): *bilan* (balance sheet) and *état des resultats* (income statement).

Key figures from AGAPCO's income statements for the past four years are shown in Table 2, and graphic illustrations of financial trends on both the income statements and balance sheet are shown in Figures 4 through 9.

In order to create a consistency that allows comparison of the annual financial statements, we have made two adjustments to the original statements.

First, USAID grant funds were not recognized on the income statement as revenues in 1985 and prior years, but were included under *revenues de subvention et autres* during 1986 and beyond. In order to calculate the operating deficits for each year, donor funds have been removed from the revenues for 1986, 1987, and 1988.

Second, the costs of drugs destroyed (usually expired) were included as part of the *cout des ventes* (cost of drugs sold) in 1985 and 1986, and under *frais d'operation* (operating costs) in 1988; like the USAID grant support, these costs have been removed from the original line items and listed separately below.

TABLE 2 - AGAPCO ETAT DES RESULTATS
(Note: Read text for clarification)

	1985	1986	1987	1988
REVENUES:				
VENTES NETTES	$269,802.19	$386,883.94	$400,322.60	$502,040.80
COUT DES VENTES	$260,674.99	$328,393.28	$321,150.08	$430,102.02
MARGE BRUTE	$9,127.20	$58,490.66	$79,172.52	$71,938.78
FRAIS D'OPERATION:				
DON ET CONSIGNATION	$115,922.14	$58,722.53	$46,760.52	$15,751.59
SALAIRE	$94,025.00	$120,125.75	$144,677.55	$169,826.90
AUTRES	$82,058.74	$115,979.57	$93,273.72	$95,859.28
TOTAL DEPENSES	$292,005.88	$294,827.85	$284,711.79	$281,437.77
REVENUES - DEPENSES	($282,878.68)	($236,337.19)	($205,539.27)	($209,498.99)
PRODUITS GASPILLE	$360,000.00	$270,000.00	$0.00	$121,403.09
OPERATING DEFICIT	($642,878.68)	($506,337.19)	($205,539.27)	($330,902.08)
DONOR SUPPORT	-?-	$507,355.59	$223,125.49	$88,244.60
PROFIT/DEFICIT	($642,878.68)	$1,018.40	$17,586.22	($242,657.48)

FIGURE 4
(repeat of Figure 1 in Executive Summary)

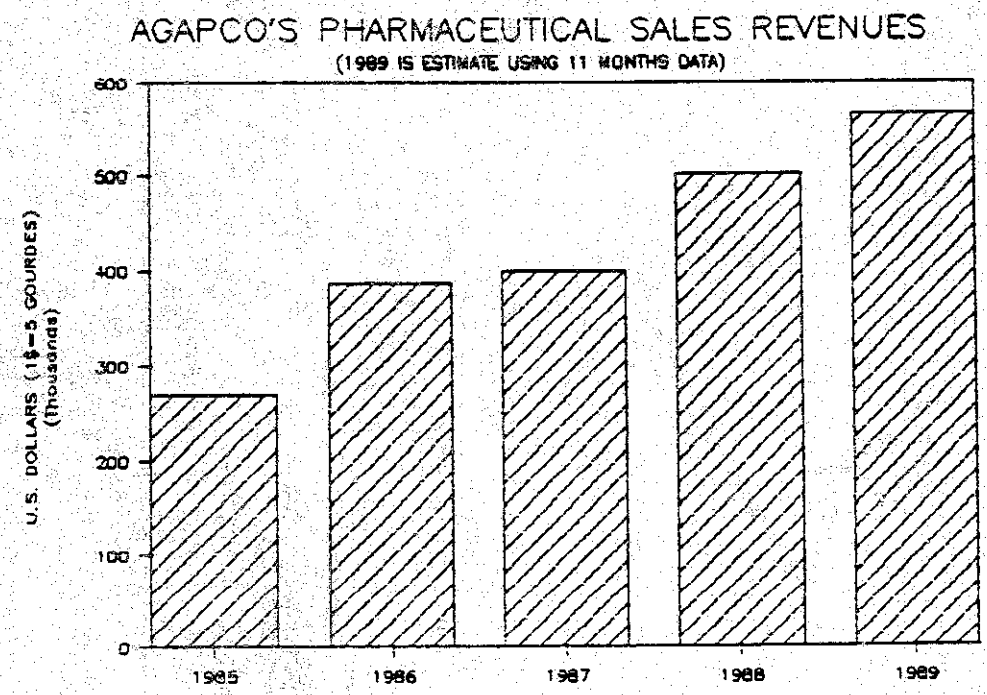


FIGURE 5

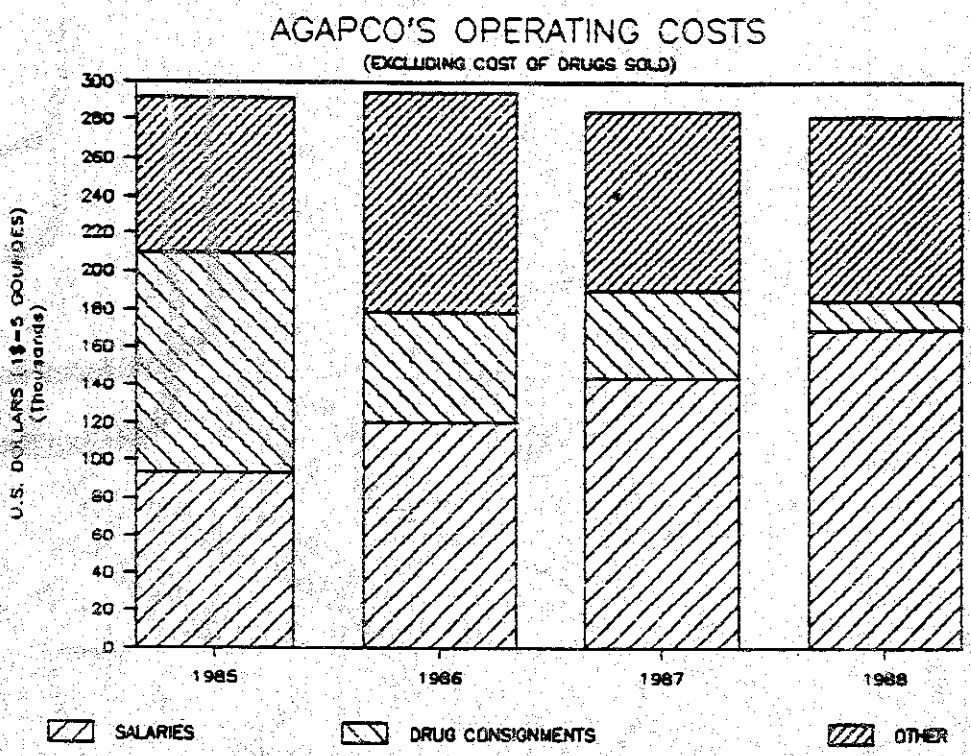


FIGURE 6

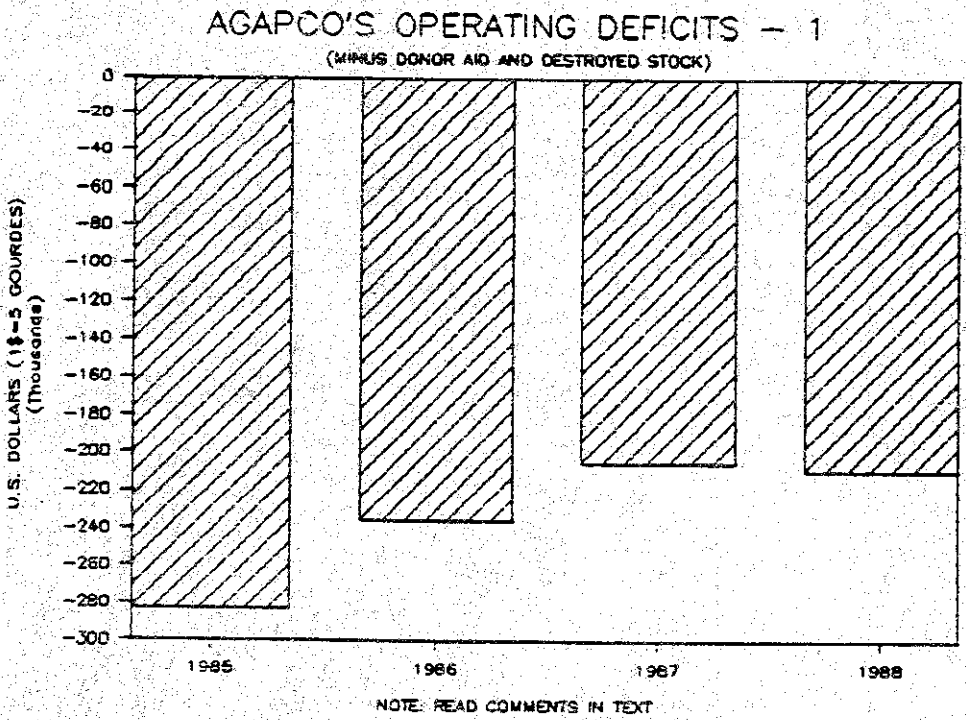


FIGURE 7

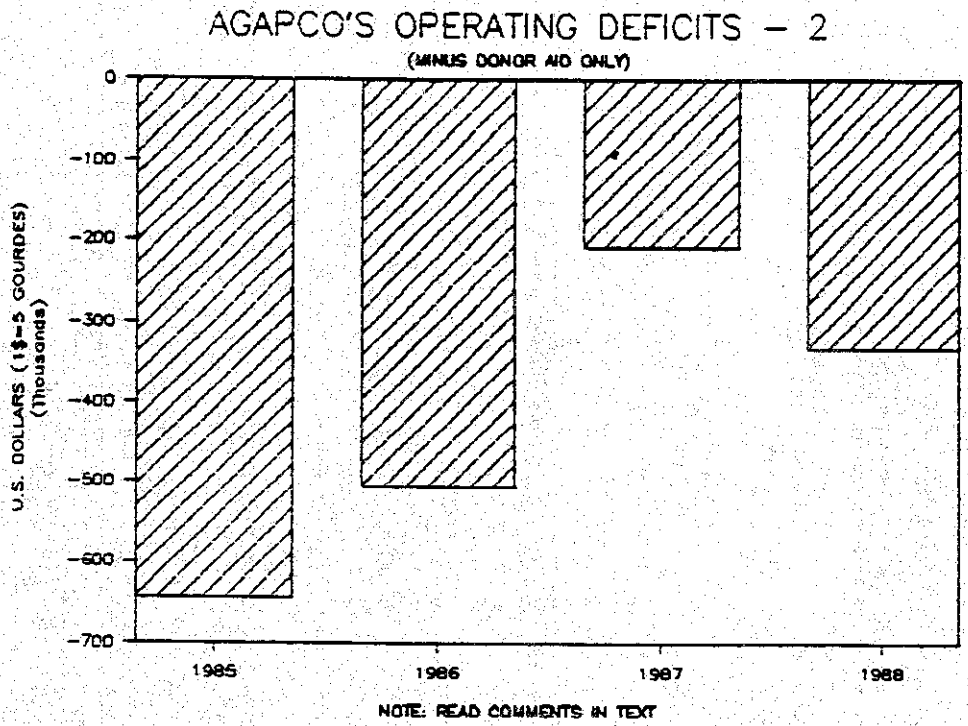


FIGURE 8

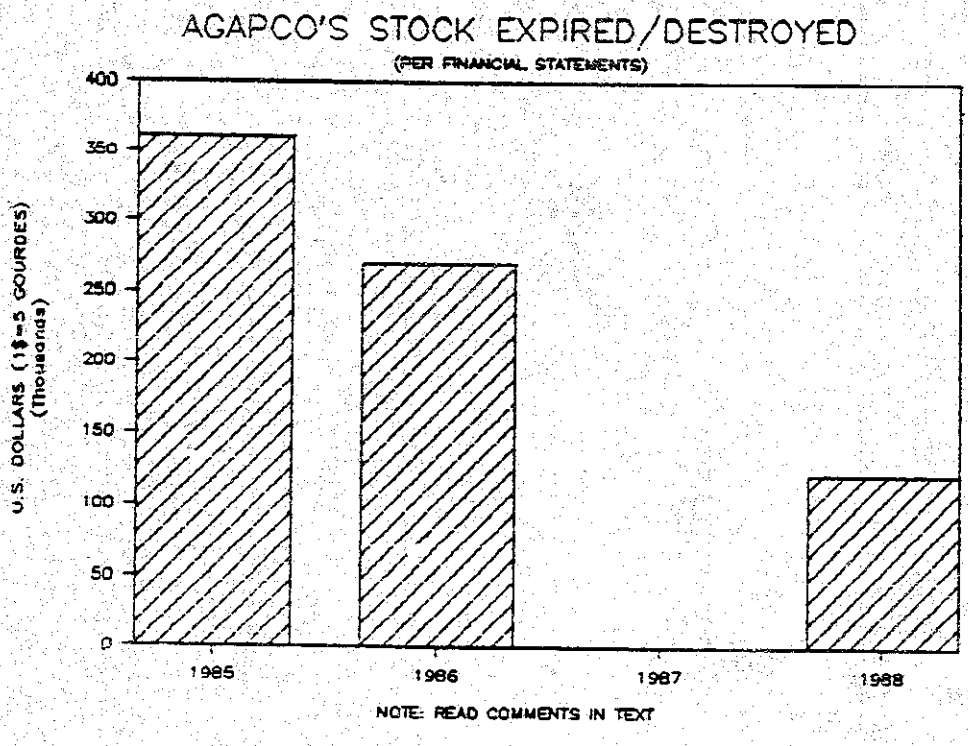


FIGURE 9

AGAPCO – SELECTED ASSETS

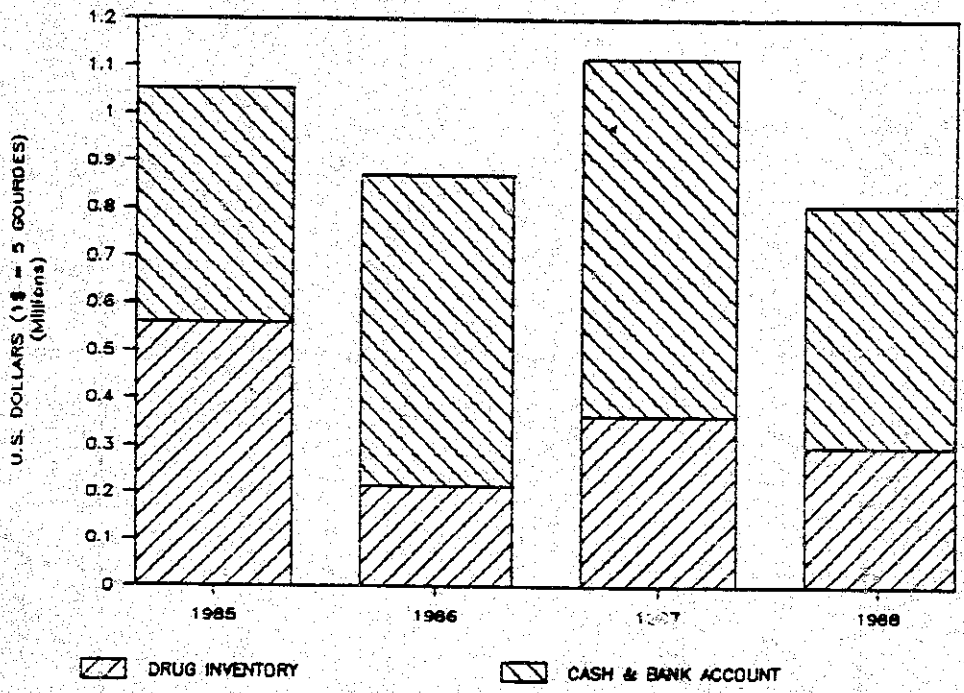
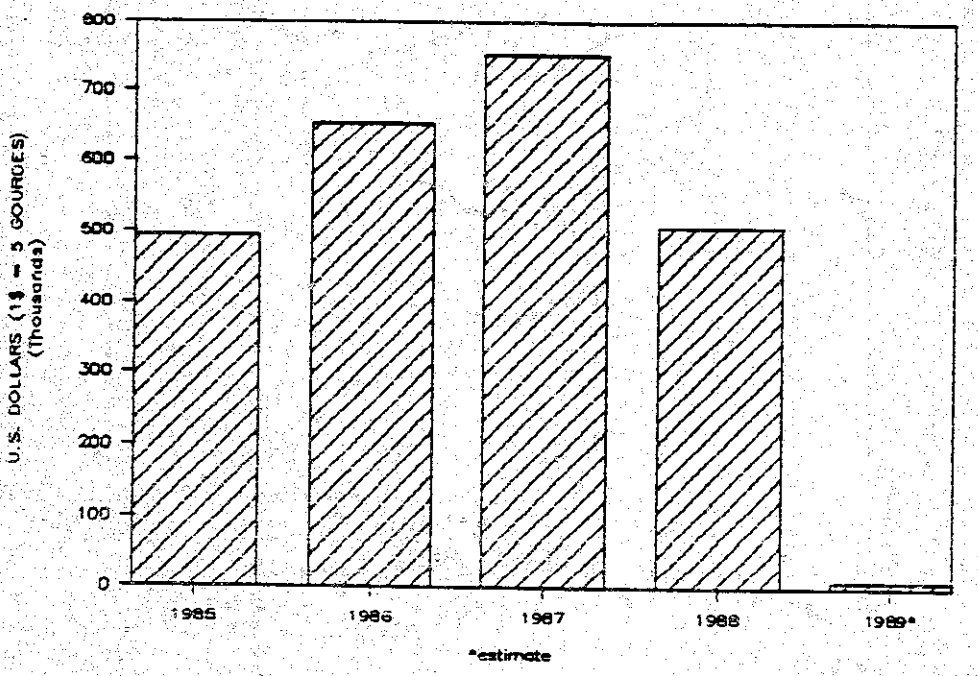


FIGURE 10

AGAPCO – AVAILABLE CASH



All of the following comments on financial trends at AGAPCO assume the official exchange rate (i.e. 5 gourdes = 1 U.S.$), and all figures are in U.S. dollars. The parallel market for foreign exchange has been rising rapidly recently, however some economists believe that this is largely due to government efforts to control the parallel market. As the risk of participation in the parallel market increases, the rates of exchange will rise accordingly. Some economists believe that the real differential for the gourde, without governmental exchange controls, is between ten and twenty percent (10-20%). If this is the case, it is approximately the same parallel market differential that existed in the earlier years shown here, 1985 and 1986.

Figure 4: Revenues have been rising steadily over the five year period, and, since revenues are a reasonable surrogate for drugs distributed, this is the best indicator that AGAPCO has been moving in a positive direction. Revenues for fiscal 1989 are estimated based on eleven months of data, so they should be quite accurate.

Figure 5: Operating costs, excluding the cost of drug procurements, have declined slightly. Given that there is normally a gradual increase in operating costs due to inflation, this is also an excellent trend. Only four years of data were available for operating expenses. During August of 1989 approximately fifty-three thousand dollars ($50,000) was paid out of the main AGAPCO bank account. Over fifty percent (50%) went toward the purchase of drugs; of the remaining operating expenses, over twenty-five percent (25%) was for personnel. If August was a typical month for operating costs, then fiscal year 1989's operating costs should be very close to 1988's.

One reviewer of this report in draft commented on the rise in salary levels. The year-by-year salary increases were 28% (1985-86), 20% (1986-87), and 17% (1987-88). Increases for the first two years were approved and funded under the USAID grant. The 1987-88 increase was more modest and, without good data about the combined impact of inflation and devaluation in Haiti, it is difficult to comment on its appropriateness. It could be quite useful for USAID to compare individual salary levels with current equivalent posts in AID-funded projects, particularly if further funding of operating costs is considered. Also, as mentioned in Section II, staffing levels could also be reviewed.

Figures 6, 7 & 8: Deficits have, in general, been declining. If the loss associated with expired drugs is taken into account, then there was a rise from 1987 to 1988. However, it generally takes several years for drugs to expire, so the results of poor procurement decisions do not show up in the financial statements until some time after management has taken the decisions. Therefore, the losses through drug expiration recognized in 1988 are probably the result of procurement decisions made in 1985 or even earlier. In fact one side benefit of what is otherwise a very poor procurement methodology is that hand-to-mouth operations result in a minimum of stock wastage. AGAPCO's management antic-

ipates that minimal or no stock expiration will have been experienced during fiscal year 1989.

Several reviewers of the original draft of this report asked how deficits have been financed. During the years of USAID funding, AID covered the deficits as well as all operating costs and most drug purchases. This meant that AGAPCO accumulated cash surpluses through the sales revenues. These have served to support AGAPCO and finance the deficits since the AID funding was stopped.

Figure 9 & 10: Since USAID funding did not terminate until November of 1987, when AGAPCO's fiscal year had ended, fluctuates in cash and the value of drug inventories are due to the writeoffs of expired drugs and the accumulation of cash through sales revenues during the years from 1985 through 1987. As noted earlier, USAID was funding all of the operating costs and some of the drug purchases. In 1988, we see the beginning of the decapitalization, as available cash was converted into drug inventories.

The decapitalization during fiscal year 1989 was accelerated when approximately two hundred thousand dollars ($200,000) was used by the MSPP to renovate, equipe, re-open, and make functional 24 hours a day (instead of 6) health centers, dispensaries and hospitals throughout the country. Documents supporting the requests and disbursements are available in the AGAPCO accounting files, and since the MSPP (along with AGAPCO) has suffered from the termination of USAID funding to the public sector, these transactions are perhaps only the expected result of multiple pressures on the government system. Nevertheless, these particular disbursements recall the issue of AGAPCO's real and perceived financial autonomy (as stated in the law that created AGAPCO) and must be taken into consideration as future funding to AGAPCO is considered. At the end of August, the combined balances in AGAPCO's two bank accounts was approximately ten thousand dollars ($10,000); balances for the two previous months were slightly higher. Thus, the cash flow situation is very grave.

Pricing Policies: In late 1985, a detailed analysis of AGAPCO's pricing policies and their impact was conducted. Multiple problems and complications were identified. It was not within the scope of this evaluation to do an in-depth analysis of current pricing policies, but it is clear that many of the same problems still exist. (See report: "Financial Management and Planning in AGAPCO," December, 1985.)

AGAPCO's mark-up for wholesale prices (i.e. from AGAPCO to the pharmacies) can range from a negative thirty-seven percent (-37%) to two hundred percent (200%) over AGAPCO's own unit purchase costs. The real overall average markup is not measured, since various products sell in higher or lower volume, nor is it projected based on the past volume of sales. Except for anecdotal information, competitive market prices are also not surveyed in order to assist in AGAPCO's pricing policy formulation.

AGAPCO also sets suggested retail prices for the pharmacies, although not all of the pharmacies necessarily use the AGAPCO price list. (One of the pharmacies in Port-au-Prince noted that they hadn't received a copy of the price list; we didn't solicit this information in other pharmacies.) In general, mark-ups for the suggested retail prices are from ten to thirty percent (10-30%) over AGAPCO's wholesale price. Again, there is no calculation of the true average mark-up, particularly given a higher or lower volume of sales for specific products; competitive market data are also not used in the pricing decisions.

In addition to complex and confused pricing policies, cash flows (rather than real surpluses or margins) are being used as the basis for retaining "profits." The stated policy is for the pharmacies to retain eight percent (8%) of their total revenues, although the first pharmacy we visited was still calculating a retained thirty percent (30%) -- a policy that was in effect three years ago. Clearly, as was true in the past, there is a divergence between stated policies and actual practice, and the amount stated in policies as the percent to retain as "profits" is not related to the true profit margins that the pharmacies are earning. While AGAPCO has no real authority over practices in individual pharmacies, it should be informed about actual practices and attempt to use its stated policies to advise and influence practices in the pharmacies.

This is an area where AGAPCO could benefit from technical assistance even before the recommendations in the executive summary have been implemented. Since problems that existed four years ago have persisted or increased, if funding is available some external assistance should be provided in this area soon. However, in the meantime, AGAPCO staff should be able to make some progress without increasing current expenses and without external assistance. Some suggestions are sketched out in the following paragraphs.

Particularly while the central office staff has available time, they can begin to collect data on both wholesale and retail prices for brand and generic names that are identical to or substitutes for AGAPCO products. This information should be categorized based on the type of facility (or individual including market ladies) from which the drugs were available, as well as the location (i.e. urban or rural). Since AGAPCO has less real control over the retail prices, it would be best to concentrate on wholesale prices first. Some of AGAPCO's lower-priced products may be selling very quickly, while the higher-priced products are not selling at all. AGAPCO should also investigate how many of the pharmacies are following AGAPCO's suggested retail prices, and how many have continued to retain 30% of the revenues. Once data are available, pricing policies should be reconsidered. The Director General (or Technical Director), and the Chief Accountant should be involved in the decision-making process, but the data collection should be done by the two Supervisors and the Promotion Manager under the guidance of the Direc-

tor General (or the Technical Director).

The staff can also construct lotus spreadsheets on the computer that track sales volumes at the AGAPCO wholesale level in relation to the various price margins. This would allow them to calculate the true gross margin that AGAPCO is experiencing. Although this is shown on the income statements it is probably distorted by inevitable miscalculations in the stock valuations. Also this information should be monitored on a monthly basis, or at least sampled regularly.

Exactly the same thing should be done for a sample of pharmacies in order to calculate the true margins at the retail level. Also, the stated policy of retaining thirty percent of the revenues should be revised for the pharmacies that are still following it. With the exception of the six pharmacies described under Section IV, we were unable to examine the record keeping systems in individual pharmacies in the AGAPCO network. Although the record keeping systems are appropriately simple, period supervision, the provision of printed forms, and occasional refresher courses will be necessary to maintain them in the long term.

VI. SUPERVISION, COMMUNICATION & PROMOTION

Twenty-six (26) of the AGAPCO staff members, or seventy-four percent (74%), are based in Port-au-Prince. Nine (9) of those based in Port-au-Prince, including the *chauffeur*, travel out of the city as part of their jobs. The *Superviseur Generale*, the *Superviseur*, and the *Responsable Promotion* travel out to visit the AGAPCO system most frequently. The Administrator estimates a total of approximately three hundred (300) person days per year of staff travel, including about twenty-five (25) days for minimal training activities and taking physical inventories at AGAPCO'S regional and district depots. Of those based outside of Port-au-Prince, most staff members are responsible for the management of a regional or district depot and therefore do not leave the warehouse to either supervise or promote.

This means that many of the most remote AGAPCO pharmacies do not receive a promotional or supervisory visit from AGAPCO for a full year and very few pharmacies that are out of the metropolitan area receive a visit every six months. Nevertheless, during recent years, AGAPCO personnel have begun to work more closely with the doctors, nurses and other health providers at the district and regional levels. Meetings have been held more frequently, and notes are kept on discussions, but, because of the lack of funds for travel, the frequency of these meetings has declined during the most recent period. However, they are continuing when possible. These visits will probably always continue to more focussed on promotion than supervision; however, the supervisors should also using a standard set of supervisory protocols. Protocols were previously developed for AGAPCO (e.g. listing stock-outs in individual pharmacies and monitoring monthly revenues), but they do not appear to be in use now.

The visits that focus on developing relationships with the health team are an excellent strategy for AGAPCO to follow, and this should continue to the maximum extent possible. Word-of-mouth communication and the development of personal relationships with other heath care professionals is probably the most effective way for AGAPCO to promote itself. This has also proven to be the most effective promotion strategy for commercial drug companies who send "detailers" to visit retail outlets and doctors regularly.

The same word-of-mouth promotion can continue, particularly through the Director General and the Technical Director, at a higher level. They should continue to meet regularly with influential doctors, particularly those at the University or in key managerial positions, and to develop personal relationships that will eventually support AGAPCO as a whole. These professionals can also give AGAPCO management honest feedback on how the organization is perceived by health professionals and what aspects of the organization need to be changed or what misperceptions need to be corrected through communication.

In the longer-term AGAPCO needs to develop the role of the *Conseil d'Administration*. This body has the potential of being a powerful mechanism for developing AGAPCO's role in the health care system. A visit to St. Lucia and the ECDS by the Minister of Health and the Director General of AGAPCO should help them develop ideas on how to better develop the *Conseil d'Administration*, and perhaps ancillary committees.

Exhibit I is an article that appeared recently in a local newspaper. The article, written by a journalist and based on an interview with the Director General, is an excellent example of how AGAPCO should promote itself without spending money on advertising. Particularly when such articles appear in newspapers that are not considered propaganda vehicles by the general public, they can be much more powerful than commercial advertising since they highlight the non-profit social goals that are one of AGAPCO's attributes. AGAPCO should capitalize on this type of promotion by meeting with the press as often as possible, particularly to announce special meetings, new activities, and other events that might be of interest to newspaper readers.

In terms of other kinds of promotion, through advertising, the needs are modest until AGAPCO has organized the rest of its operations well. The products must be available. The prices need to be appropriate. Individual pharmacies should be better organized (i.e. cleaned and organized neatly), because the appearance of the pharmacy itself has a major impact on the confidence of both patients and health care workers. It is not a good idea to make major advertising efforts until they system is functioning properly because, if patients or health care professionals are attracted by the advertising and then disappointed in the reality of AGAPCO pharmacies, this can result in increased negative word-of-mouth advertising.

In the longer-term, if funds become available, AGAPCO most needs to develop and publish a new vademecum that can be widely circulated to prescribers and other health care professionals in Haiti. Aside from the need to reconsider the list of drugs in the current vademecum, as one should do annually for any formulary process, the published vademecum should be AGAPCO's best promotional/educational vehicle for providers in the health care system and probably a core promotional activity. In the short-run, the Director General plans to print a list of generic and brand name drugs that are cross-referenced so that health care professionals who are familiar with brand names will begin to recognize the generic brands offered through AGAPCO facilities. This is an excellent idea and should be pursued immediately.

Other types of promotion that should continue include the production of white plastic bags with the AGAPCO logo that are used to hold small sachets of AGAPCO products; this bags improve the appearance and sense of order in the pharmacies. Price lists and some of the other printed materials should continue. However, the current shortage of funds, has reduced the production of these materials along with printing of administrative forms.

EXHIBIT I

Pharmacies Communautaires

AGAPCO: la politique du meilleur prix

«Nous visons les petites bourses, mais nos produits sont à meilleur marché, et de bonne qualité». C'est ce que nous a déclaré, au cours d'un entretien à son bureau, Dr Mario Samson, Directeur Général de l'Agence d'approvisionnement des pharmacies communautaires - (AGAPCO). Selon lui, l'AGAPCO préfère utiliser le nom générique des médicaments au lieu du nom commercial. Pourquoi? En réponse, Dr Samson nous a laissé entendre que cela contribue à augmenter la gamme des médicaments de l'agence et l'empêcher de faire des dépenses superflues pour emballage et publicité car l'agence, ajoute-t-il, entend desservir tous les hopitaux, centres de santé et dispensaires du pays.

En distribuant ses produits, d'après le Dr Samson, l'AGAPCO n'a pas l'intention d'entrer en compétition avec les autres pharmacies établies sur le marché, d'ailleurs, elle n'en a pas le droit parce qu'elle est une institution à but non lucratif.

Son objectif premier, selon son directeur général, c'est «de permettre aux démunis de se procurer les médicaments à bon marché».

Les Sources d'approvisionnement

L'AGAPCO peut donc se permettre un tel luxe, car elle s'approvisionne en médicaments à l'UNIPAC [UNICEF Parking Center], une filiale de l'Unicef qui fournit les produits à très bon marché. De plus, l'AGAPCO achète de Pharval et de 4C. Ces agences acceptent de vendre à meilleur prix à l'AGAPCO qui poursuit un but social et humanitaire. Les mêmes médicaments écoulés par ces agences sur le marché local sont refilés à meilleur prix à l'AGAPCO.

Perception Populaire de l'AGAPCO

Cette situation privilégié cause parfois de passagers problèmes à l'AGAPCO. Une certaine propagande laisse entendre que les médicaments de l'AGAPCO ne sont pas de bonne qualité. Questionné à ce sujet, le Dr Samson nous a affirmé, de manière catégorique, que les médecins qui prescrivent dans les hopitaux, les centres de santé où les dispensaires, les médicaments vendus par l'AGAPCO sont très satisfaits. D'ailleurs, ajoute le Dr Samson, nos produits s'écoulent rapidement.

FONCTIONNEMENT DE L'AGAPCO

Puisque l'AGAPCO est une institution autonome, celle-ci vit presentent avec le pourcentage [entre 2 à 10%] tiré de la vente des produits en pharmacie communautaire. L'agence s'organise, tant bien que mal, pour être auto-suffisante. Actuellement, elle a un effectif de 40 employés. Cependant l'agence fonctionnait dans le temps, avec l'aide de l'AID. Maintenant, la direction s'attend à la reprise de l'aide pour intensifier l'action de l'AGAPCO sur le terrain.

On doit noter que l'AGAPCO qui est créée par décret [Août 1982] est autonome et dirigée par un Conseil d'Administration formé des ministres des finances, du commerce, des affaires sociales, de la santé publique. Ce dernier préside le Conseil.

Politique de l'AGAPCO

L'AGAPCO couvre à 60% les hôpitaux, centres de santé et dispensaires du pays, d'après le Dr Samson, Directeur général de l'institution. Selon lui, une équipe d'évaluation de l'agence sillonne actuellement le pays et a déjà visité la région Nord, la région transversale etc afin d'"évaluer" les besoins en pharmacies communautaires.

D'après le Dr Samson, l'AGAPCO met sur pied une politique d'intégration des directeurs de région et/ou de district dans la gestion et le contrôle des médicaments en province.

Perspectives

Questionné sur les perspectives d'avenir d'AGAPCO, le Dr Mario Samson nous a laissé entendre qu'il voudrait faire de l'AGAPCO «une vraie agence d'approvisionnement» pour tous les hôpitaux, les centres de santé et dispensaires du pays. De plus, l'AGAPCO travaille pour monter un laboratoire pour contrôler la qualité des produits qu'elle vend sur le marché.

Malgré les problèmes du coût de la vie, le Dr Samson nous a assuré, enfin, que l'AGAPCO entend toujours fournir ses produits à des prix abordables. Tant mieux!

W.L.

Le Nouvelliste
Fondé en 1898
198, Rue du Centre
TÉL: 3-2114 / 2-4754

Directeur: Lucien Montas
Gérant Responsable: Max E. Chauvet
Administration: Clarence Pierre-Pierre
Distribution: Louis Marsan
Publicité: Mme Yolette Jacques

VII. AGAPCO'S FUTURE NEEDS & RELATED DONOR ACTIVITIES

Both the Minister of Health and the Director General of AGAPCO expressed interest in adding a production unit for dextrose (intravenous) solution to AGAPCO's operations. There is currently a production unit at the Schweitzer Hospital that is apparently operating effectively and producing solution at a fraction of local wholesalers prices. We investigated the possibility of AGAPCO adding production of dextrose to its portfolio of activities by consulting major manufacturers in the U.S. and a production specialist who was a short term consultant to AGAPCO in 1985.

The production technology, while relatively simple from a drug manufacturing company's perspective, is very complex compared to anything AGAPCO is doing. Good quality containerization products for dextrose solution can be expensive and difficult to obtain, e.g. rubber and glass products. In other words, the expensive components of the process must be imported. A sterile environment is essential. Dextrose solution production is more sophisticated than the production of Oral Rehydration Salts which was shown not to be cost effective in a country the size of Honduras. A major manufacturer did a study and decided it was not cost effective to produce dextrose solution in Trinidad or Panama; quality assurance would also have been a problem in both countries.

The packaging operation at AGAPCO, which is very simple by contrast, has never operated at satisfactory standards, nor has it been cost effective. (Several earlier reports document this.) AGAPCO management is not experienced in the management of a production process, and the organization is already relatively complex and has many problems to solve in its current operations.

Since both the Minister and AGAPCO's Director General were very interested in the production of dextrose solution at the Deschappele hospital and replicating this within AGAPCO, they may want to investigate this further despite the negative recommendation that results form our investigations. If so, we would suggest that the starting point should be existing manufacturers in Haiti. Are they producing dextrose solution? If yes, what are the cost components and the quality assurance standards? If not, why not?

The World Bank is in the final stages of developing a major health sector project that will assist the MSPP in improving health care delivery in the Region Ouest, covering approximately one-third of Haiti's population. Although negotiations are still underway and the project is not expected to be implemented until early 1990, discussions indicate that it will include support to AGAPCO through the some capital acquisitions (e.g. two vehicles), the provision of technical assistance, and the procurement of a limited list of essential generic (~30) drugs. It is expected

that these drugs will be procured by PAHO/Washington. Optimistically, this means that AGAPCO will not receive drugs through the project until at least mid-1990.

Since the project is still in the negotiation stage, detailed plans are not available. However, the two pharmaceutical consultant reports produced during the project design stage should provide useful perspectives. One report provides detailed analysis on the appropriateness of the current pharmaceuticals available through AGAPCO and the published vademacum. The other tends to concentrate on the development of pharmaceutical laws and private/public system choices. Although Haiti is lacking any legal structure related to pharmaceuticals and some legal changes are possible, it is probably not realistic to expect a comprehensive legal system related to pharmaceuticals to be implemented in Haiti during the next decade. The WHO paper on developing pharmaceutical laws begins by stating that it is not useful to develop new laws related to pharmacy practice and pharmaceuticals unless the country has the infrastructure to enforce the laws.

Aside from its potential role as a drug procurement agency for the World Bank Project, PAHO has no explicit plans to assist AGAPCO. However, PAHO has shown interest in AGAPCO and will fund the travel expenses of the Minister of Health to visit the ECDS in St. Lucia. If AGAPCO and the ECDS were interested in developing a longer term relationship, it might also be possible for them to receive partial support (e.g. travel expenses) through PAHO's Technical Cooperation between Developing Countries (TCDC) program. Also, a Health Economist with African experience in public sector drug sales programs may be joining the PAHO/Haiti staff, and, although he will have other responsibilities, his expertise could be tapped by AGAPCO management.

The Interamerican Development Bank (IDB) also apparently has plans to assist in the development of the health sector, but these are in a nascent stage.

We were unable to arrange a meeting with the UNICEF Representative. However, it is important to make contact with UNICEF to ascertain whether or not AGAPCO can purchase through UNICEF and make payments in gourdes, ans to obtain estimates of current UNICEF lead times for procurement planning purposes.

At the present time USAID has access to approximately one hundred thousand dollars ($100,000) through Title II/PL480 funds. The Director General has prepared a budget request for these funds and presented it to USAID staff. There is also some possibility of funding through private sector projects funded through the mission and centrally funded projects. These possibilities should be pursued. In addition USAID intends to fund the travel expenses of AGAPCO's Director General and one USAID staff member to visit the ECDS in St. Lucia with the Minister of Health.

Since finance, management, and development of the public sector/non-profit market, are the most pressing needs in the pharma-

ceutical sector, these are the areas were technical assistance would probably be most beneficial for AGAPCO. In the areas of medicine and pharmacology, technical assistance should be primarily from Haitian advisers, so as to avoid the errors made in product selection in the past. Product selection must be begin from a base of existing demand in Haiti, although it will be important to influence changes in that demand through social marketing techniques. Technical assistance should be available through the upcoming World Bank project, but it might also be tapped through local or centrally funded USAID projects. As noted in Section V, it would be valuable to provide external assistance on pricing policies sooner if funding is available.

However, although AGAPCO can benefit from specific types of technical assistance, its most pressing need is for financial assistance in the procurement of pharmaceuticals. The next priority is for the support of specific types of development costs, i.e. training courses for regisseurs, seminars that inform providers about the range of essential, generic name drugs that are available, printing costs for various promotional/information materials and administrative forms, and the purchase of vehicles. Some subsidization of recurrent costs will clearly be necessary either through the MSPP or through donor support.